DENTAL PLAN - BENEFIT YEAR 2003

Administered by Blue Cross/Blue Shield of Montana
1-800-423-0805 or 444-8315 • www.bluecrossmontana.com

DEDUCTIBLE OF $50.00 PER PERSON APPLIES BEGINNING 07/01/03(excludes Type A preventative services). A MAXIMUM YEARLY BENEFIT OF $1,000 FOR ALL SERVICES WILL BE IMPLEMENTED 07/01/03.

Monthly Premiums

Member only	$28.60
Member and spouse	$34.60
Member and children	$41.60
Member and family	$46.60
Joint Core	$32.60

Covered Services	Plan Pays	Limitations/Maximums
Type A: Preventive and Diagnostic	• 100%**	• One full-mouth X-ray or series in any 36-month period. • One set of supplementary bitewing X-rays in any 180-day period. • One exam and/or cleaning in any 180-day period. (Fluoride application covered through age 19.) • Subject to $1,000 yearly maximum • Not subject to deductible
Type B: Fillings, Oral Surgery, etc.	• 80%**	• Subject to $50.00 deductible • Subject to $1,000 yearly maximum
Type C: Dentures, Bridges, etc.	• 50%**	• Subject to $50.00 deductible • Subject to $1,000 yearly maximum • Replacement crowns limited to once every five years. • Replacement dentures limited to once every five years. • $10,000/lifetime for endentulous Dental Implants ***Prior authorization required. Yearly maximum also applies.*** • Dental sealants – limited to covered dependents under age 16 – may be applied to molars once per tooth per lifetime.

**Of allowable charges.

WHO IS ELIGIBLE?

Employees are required to elect dental insurance unless they waive benefts. You may also choose which dependents may receive coverage within 31 days of your date of hire or within 63 days of a qualifying event such as a marriage, birth, or adoption. Adding a dependent to the plan requires the submission and approval of an application, except for children under 3 years of age. Applicants will be required to have outstanding dental problems identified during the application exam and corrected before joining the plan.

Dental plan benefits are paid differently depending on the type of service received.

The deductible of $50.00 per person applies begininng 07/01/03. Deductible does not apply to Type A preventative services.

Each member and dependent has a maximum yearly benefit of $1,000 for all dental services incurred in 2003 and subsequent plan years.

If you use a Blue Cross participating dentist, you will not be responsible for costs beyond the allowable charges for covered services.

TYPE A SERVICES

The Dental Plan pays 100 percent of the allowable charges for Type A Services and are not subject to deductible:

1. Diagnostic – Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment. Dental X-rays are limited to one full mouth X-ray or series in any 36-month period and one set of supplementary bitewing X-rays in any 180-day period.

2. Preventive – Oral examination, including prophylaxis (cleaning) and topical application of fluoride for dependent children under 19 years of age, but *not more than one examination and/or application in any 180-day period.*

3. Unscheduled minor emergency treatment to relieve pain.

TYPE B SERVICES

The Dental Plan pays 80 percent of the allowable charges (after deductible) for Type B Services:

1. Passive space maintainers
2. Extractions
3. Fillings
4. Mucogingivoplastic surgery
5. Endodontics
6. Periodontics
7. Oral surgery

TYPE C SERVICES

The Dental Plan pays 50 percent of the allowable charges (after deductible) for Type C Services:

1. Crowns, bridge abutments (bridge retainers crowns), inlays, onlays, pontics and gold and porcelain fillings. Replacement of crowns is limited to once every five years.

2. Bridges.

3. Repair and rebasing of existing dentures.

4. Initial and replacement dentures, limited to no more than one set of replacement dentures in any 5-year period.

5. Up to $10,000 for endentulous Dental Implants per lifetime. (Prior authorization is required and is subject to yearly maximum).

6. Dental sealants, limited to covered dependents under age (16) applied to molars once per tooth per lifetime. Repair and resealing are not covered.

Type C Limitations

Type C Services (except replacement dentures) are payable after 12 months of continuous coverage under the Plan. Replacement dentures are payable after 36 months of continuous coverage (waiting periods may be eliminated or reduced by a Previous Coverage Credit).